STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155100	A. BUILDING 00 B. WING	08/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA	2111 NORTON LN BEDFORD, IN47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00094180 and IN00094849. Complaint IN00094849 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00094180 - Substantiated. State/Federal deficiencies related to the allegations are cited at F318. Survey Date: August 16, 2011 Facility Number 000040 Provider Number 155100 AIM Number 100274460 Survey team: Marla Potts, RN,TC Melinda Lewis, RN Census bed type: SNF: 11 SNF/NF: 138 Total: 149 Census payor type: Medicaid: 117 Medicare: 19 Other: 13 Total: 149	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 6 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/18/11 by Suzanne Williams, RN			
F0318 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on record review and interview, the facility failed to ensure passive range of motion was provided to a totally dependant for care resident, Resident C, for 1 of 3 residents reviewed for range of motion, in the sample of 6. Findings include: Resident C's clinical record was reviewed on 8/16/11 at 7:15 A.M. Diagnoses included cerebral palsy. A typed note concerning things "About me and My Diagnosis," provided by a family member, included "Giving (name of Resident C) a massage and Range of Motion every day is a must. He receives Botox every 3 months and if you do not consistently do therapy with him it will be unbeneficial..."	F0318	What corrective action will be accomplished for those residents found to be affected?Resident C was a short term Respite patient and only stayed the 9 days as scheduled. Staff state that they did complete range of motion and a daily massage on Resident C during his daily bath and verbally described his as "tight." As Resident C was a Respite patient scheduled to stay with us for only 9 days, a formal documentation program had not been established although standard passive range of motion was being completed during his daily bath.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents including Respite Stay Residents restorative assessments/plans were reviewed and revised as	09/06/2011

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	The most recent MDS (minimum data set) assessment, an admission assessment, dated 6/14/11, indicated the resident was admitted 6/5/11, and was dependant on staff for transfers, dressing, eating and hygiene, and had limitations in range of motion on both sides of the upper and lower extremities. A Restorative Nursing Assessment, dated 6/7/11, indicated the resident was not able to follow instructions, extremity tone was spastic, had limitations in range of motion of right and left sides-neck, hand including wrist or fingers, leg including hip or knee, foot including ankle or toes. Nothing was documented under loss description. Recommendation for restorative or maintenance programs was: Passive range of motion. Nothing was documented under specific instruction and number of repetitions for Range of Motion. The care plan, dated 6/7/11, did not include a problem or interventions concerning Range of Motion. During interview with the Unit Manager of the unit where Resident C resided, on 8/16/11 at 8:00 A.M. she indicated she had checked and there was no documentation of range of motion having been competed for this resident. She indicated the CNAs state they do range of motion on all		needed.What measures will be put in place or what systemic changes will you make to ensure the alleged deficient practice will not recur?Nursing staff inservices were completed on August 26, 2011. A copy of the Therapy Screens will now be placed in the ADON office for review by the IDT team three times weekly for timely completion. Any screens found that have not been completed timely will be addressed with the therapy department during the Morning Update Meeting to maintain compliance.How will the corrective action be monitored to ensure the alleged deficient practice does not recur?Audit of the therapy screen completion will be completed by the DON or designee and presented at QA&A monthly.By what date will the systemic changes be completed?Systemic changes will be completed by September 6, 2011.	

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	residents but it was not documented. The Unit Manager indicated a therapy screen had been requested, and provided the screen request dated 6/6/11. During interview on 8/16/11 at 8:30 A.M. with Therapist #1, the head of the therapy department, he indicated he could find no screen having been completed. This federal tag relates to Complaint IN00094180. 3.1-42(a)(2)			